noble mission it is to relieve suffering—'the blessing of her who was ready to perish.' "—*British Med. Journ.*, Dec. 28th, 1861.

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47. *Rules for Ovariotomy.*—Mr. T. SPENCER WELLS lays down the following rules for ovariotomy, the observance of which will, he believes, assist in securing a favourable result:—

"1. The operation should be performed in an airy room, the temperature of which should not be below 70° Fahr., but need not be raised to a degree, uncomfortable to either patient or surgeon.

2. The patient should be placed in the horizontal position, on a firm, narrow couch, opposite a good light, and be well covered by flannel everywhere except the abdomen and face.

3. She should be spared the fear and shock of the operation, by chloroform.

4. The incision should be made in the median line. It should not pass nearer than two inches to the symphysis pubis, and may commence just below the umbilicus. It may be extended upwards to the left of the umbilicus, and along the median line, as far as may be necessary to expose the tumour and separate adhesions. A large empty cyst may be removed through an incision three inches long; and an incision of five inches is amply sufficient for the removal of very large tumours, provided each cyst be withdrawn as it is emptied, or groups of small cysts be withdrawn unemptied one after another.

5. Any bleeding vessel in the abdominal wall should be secured before the peritoneum is divided.

6. When ascitic fluid surrounds an ovarian tumour, some of it may be allowed to escape; but the tumour should be pressed forward by an assistant to retain the fluid till the last as a protection to the intestines. Any adhesions found, whether there be ascitic fluid or not, between the cyst and abdominal wall, should be carefully separated by the hand while the cyst is full, great care being taken not to rupture any cyst. Adhesions to omentum or intestines are better left until the cyst is empty, and the adherent viscera can be seen.

7. As soon as the tumour is freed from parietal adhesions, it should be tapped by a large siphon trocar. As the fluid escapes and the cyst becomes flaccid, it is either to be fixed by a hook and withdrawn, or drawn over the canula and tied over it, to prevent any ovarian fluid from entering the peritoneal cavity.

8. As the cyst escapes, flannels wrung out of water at 96° are to be carefully wrapped round it to protect the peritoneal cavity. As secondary cysts are drawn to the opening, they are to be emptied, either by the trochar being passed on through the canula which is still tied within the first empty cyst; or by opening this cyst, passing one hand within it, and breaking down secondary cysts, while the other hand withdraws the tumour as it is emptied.

9. When there is a solid or semi-solid mass, so large that it will not pass easily through the opening, this must be carefully enlarged to the necessary extent.

10. If, as the tumour is withdrawn, omentum, mesentery, or intestine, are seen to be adherent to it, the adhesions must be carefully broken down with the fingers, or divided with the scalpel or scissors. When intestine is so firmly adherent that it cannot be safely separated, the adhering portion of cyst should be cut away, leaving it attached to the intestine, but removing the inner secreting lining membrane of the cyst.

11. Any portion of omentum separated, should be carefully held to see that no bleeding vessel is returned. Any portion which appears to be much altered from the natural condition, or torn in the process of separation, should be cut away; and any bleeding vessel should be stopped by torsion, or by ligature. If by ligature, the ends should be brought out through part of the wound. The ligature should not include any portion of omentum—simply the bleeding vessels.

12. When the whole of the tumour has been withdrawn, it will be found to be attached to one side of the uterus by a pedicle which varies very much in length and breadth, and always contains large bloodvessels. This pedicle is first compressed by the chain of an *écraseur*, or by a clamp, close to the junction of the pedicle and cyst. The tumour may then be cut away, great care being taken so to arrange the flannels that no ovarian fluid can enter the peritoneal cavity.

13. The lips of the wound are then held apart, and the opposite ovary is to be

examined. If diseased, it must be withdrawn, its pedicle secured, and the diseased organ cut away. If healthy, it is left undisturbed. A careful examination is then made, to see if there be any bleeding vessel at the spots where adhesions have been separated. Any such vessel may be secured by torsion, or by the pressure of a needle passed across it. Any blood or ovarian fluid in the abdomen or pelvis, must be carefully removed by soft sponges wrung out of water at 96°.

14. The upper part of the wound is now to be closed by passing gilded harelip pins through the whole thickness of the abdominal wall, at intervals of an inch. Each pin should perforate the skin about an inch, and the peritoneum about half an inch, from the incision on either side; so that when the two opposed surfaces were pressed together upon the pin, two layers of peritoneum are in contact with each other. These two layers adhere together very rapidly; prevent pus or other secretions of the wound from entering the peritoneal cavity; prevent adhesions of omentum or intestine to any part of the inner aspect of the wound not covered by peritoneum; and secure such firm union that a ventral hernia cannot occur after recovery.

15. The peduncle is next to be secured permanently. When the clamp does not drag on it too much, it may be left lying across the wound; but it will often be better to secure the pedicle permanently by ligature, and remove the clamp which had been used to secure it temporarily. Close below the clamp, the peduncle is transfixed by a needle which carries strong twine; and each ligature is so tied as to include a portion of peduncle of about a finger's breadth. One general ligature is then tied tightly around the whole as a security against bleeding from any vessel which may have been punctured. The smaller the portion included in each ligature, and the tighter it is tied, the more rapid is the subsequent process of separation. When the ligatures have been securely applied, the clamp is removed, and any superfluous portion of cyst is cut away; but care must be taken to leave enough beyond the ligature to prevent any danger of this slipping off.

16. When the peduncle is so long that the stump (or portion strangulated by the ligature) can be fixed outside the abdominal cavity, it is to be brought out at the lower part of the wound, and fixed there by a harelip pin, which is to be passed through it as well as through both edges of the wound. It is important that the ligatures should be on a level with the skin, and that the stump should be surrounded by dressing which separates the sloughing tissue from the raw surface. When the ligatures are fixed at the level of the peritoneum, raw surfaces surround the sloughing stump, and a sloughing condition of the wound, or putrid infection of the whole system, may possibly result.

17. When the peduncle is so short that the stump cannot be brought to the surface without great traction upon the uterus, the common practice has been to bring the ligature through the wound, and fix the free ends securely outside. In one case, they were carried through the inguinal canal beside the round ligament, and the abdominal wound was closed. In another, they were cut off short and left, the wound also being closed. It remains for further experience to determine which of these plans is to be preferred; or if only the vessels should be tied, instead of the whole thickness of the pedicle; or if acupressure can be applied successfully; or if it would be safer to trust to the *écraseur*.

18. In whatever manner the pedicle may be treated, the wound must be finally closed by a sufficient number of superficial wire-sutures, to bring the opposite edges of skin into accurate contact; and the wound may be brushed over with collodion, as an additional protection against the fetid sanies which very soon begins to surround the decomposing stump.

19. The patient is then dried, and placed in a warm bed; a hot linseed poultice, or a hot water cushion, is placed over the abdomen; and the whole is secured by a flannel belt, which is kept in its place by a pair of thigh straps.

20. The principles of after-treatment are, to secure extreme quiet, comfortable warmth, and perfect cleanliness to the patient; to relieve pain by warm and moist applications to the abdomen, and by opiate enemas; to give stimulants, when they are called for by failing pulse or other signs of exhaustion; to relieve sickness, by ice or iced drinks; and to allow plain, simple, but nourishing food.

The catheter must be used every six or eight hours, until the patient can move without pain. The harelip pins are removed on the third day, unless tympanic distension of the stomach or intestines endanger reopening of the wound. In such circumstances, they may be left for some days longer. The superficial sutures may remain until union seems quite firm. When the pedicle is kept without, the dead stump and ligatures come away between the third and tenth days; but when the stump is left within the abdomen, the ligatures have remained for several weeks. The putrid sanies which surrounds the stump must be carefully cleansed away; and the wound and surrounding skin must be protected from it by means of greased lint or collodion. The dressing should be covered by a muslin bag containing dry charcoal, or a powder of tar and gypsum, to prevent the appetite of the patient from being affected by any bad smell."—*British Med. Journ.*, Dec. 28, 1861.

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48. *Artificial Teeth with Plate lodged between the Tongue and Epiglottis.* By JAMES PAGET, ESQ.—The following case seems worthy to be added to the records of foreign bodies found in places where they were least likely to be, and producing symptoms very similar to those of organic disease.

In July, a gentleman, sixty years old, after being engaged all day in more than usually fatiguing business, and exposed to cold air, felt faint and ill in the evening, and went to his bedroom, at the hotel in which he was staying. While lying down, faint, or, perhaps, in the beginning of a slight epileptic seizure, he asked the servant to take out for him his artificial teeth—nearly complete separate sets for the upper and lower jaws. The servant, he believed, took them out. Of what immediately followed he could remember nothing more than that he became much more ill, with difficulty of breathing, and a sense of choking and suffocation, in which, in great anxiety and alarm, he sent for medical help. He was found suffering with much difficulty of swallowing and some dyspnœa. His tonsils appeared much enlarged and unusually red. These symptoms were treated, and in some measure relieved; and when one set of his teeth was missed on the day after the beginning of his illness, his medical attendants, who suspected that they might have been swallowed, were begged not to speak of them to him, for fear of the excitement and alarm that such a suspicion might excite in him. All the severity of his symptoms being subdued in a few days, the patient returned to his house at Rhyl, where Mr. Theed, as usual, attended him. For the first few days, Mr. Theed saw appearances of slight inflammation of the fauces, but these soon subsided: from that time nothing morbid could be seen in his throat. He had considerable and increasing difficulty of swallowing, was obliged to drink very slowly, and to cut all his solid food into very small fragments, and force them down his throat with gulping. Occasionally he was almost choked by food becoming involved in a tenacious mucus, which appeared to be secreted in large quantity at and beyond the fauces. Occasionally, also, he vomited after taking food. He had frequent short, "hacking" cough; and once or twice hawked up a little blood. He suffered no considerable pain; but felt constriction about his cricoid cartilage, and always referred to that part as the seat of obstruction hindering his swallowing. His voice was rough and rather hissing; his breathing sometimes with wheezing.

Many times, while watching these symptoms, Mr. Theed suspected that they were due to some foreign body in or near the larynx: but he could see none; and the patient, as often as inquiries were directed to this point, declared somewhat impatiently that the thing could not be. Especially when with the tardily given permission of his relatives, he was asked if the false teeth, which he had lost on the night of his illness, might not have slipped into his throat, he maintained that it was quite impossible; for what he had lost was a whole upper set which, he believed, had been unluckily thrown away with the water into which they were put at night. The piece was far too big, he said, to go into his throat or to be there without his knowing it. However, as none of his symptoms diminished, and he was becoming very thin and feeble, Mr. Theed, in November, brought him to London for consultation. His feeble appearance, his dull pale face, his emaciation, and the recital of his case, made me fully expect that he had cancerous stricture of the upper part of his œsophagus. On examining his